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THE QUALITY OF MERCY

FEW things a doctor does are more important than relieving pain. Yet the treatment of severe pain in hospitalized patients is regularly and systematically inadequate.[1-5] One study showed that 73 per cent of patients undergoing treatment for pain continued to experience moderate to severe discomfort.[2] This is not for want of tools. It is generally agreed that most pain, no matter how severe, can be effectively relieved by narcotic analgesics.[4,6,7] Why this inconsistency between what is practiced and what is possible?

One consideration that limits the use of narcotics is the possibility of a variety of side effects, including drowsiness, constipation, urinary retention, and most serious, respiratory depression. A more important factor is a disproportionate, sometimes irrational fear on the part of the medical profession and the public alike that patients will become addicted. The desire to protect patients from becoming insidiously drawn into a state of addiction distorts both our sense of priorities and our scientific judgment. A survey of medical house officers in two New York teaching hospitals documented the strong tendency to exaggerate the dangers of narcotics, as well as a curious belief that very low doses were effective against severe pain, and higher doses would provide no added relief.[2]

These attitudes and misconceptions have led to a rather ritualized and parsimonious use of narcotics for the relief of pain. The drugs are given in doses that are often inadequate, at time intervals that are often too long, according to a pro re nata (prn) regimen that requires the patient to wait out the time interval, no matter how severe the pain. Even the inadequate amounts of narcotics ordered may not in fact be received by the patient. The prn regimen, by placing the onus on the patient to request the drug, introduces considerations other than whether or not he is in pain. Patients may be inhibited by a desire to please the medical staff and not be a nuisance. Those who do decide to ask for pain relief must keep track of both the time and the drug schedule and have the strength and endurance to summon a nurse if one is not nearby. The extent to which nurses share the common concerns about addiction may influence their readiness to respond. Thus, in practice, the average daily dose of narcotics received is even smaller than the amounts ordered, and uncorrelated with the degree of persistent pain.[2]

We are left, then, with the image of a patient who can anticipate severe pain toward the end of each three or four-hour period, who counts the minutes until the end of the interval, and desperately hopes that a nurse will be nearby and promptly give him his dose of narcotics when it is time. To such a patient, the medical profession's attention to pain must seem confined to limiting relief from it. To doctors and nurses, on the other hand, the patient's anxiety and clock watching may seem to indicate growing dependence on the drug, not inadequate relief of pain. I believe there is a tendency for an adversarial relation-

ship to develop in which the doctor or nurse ascribes to the patient the motivations and impulsions of an addict. He is seen to be obsessed with drugs — not pain — and too weak to stop himself.

What are the facts? Addiction among patients who receive narcotics for pain is exceedingly unlikely; the incidence is probably no more than 0.1 per cent.[3,8] Even those who develop tolerance and physical dependence are unlikely to become addicted, and withdrawal can be accomplished easily if the painful stimulus is no longer present.[4,6] The purpose of the drugs for these patients is, after all, the relief of pain; "street" addicts, in contrast, take drugs for quite different purposes. The incidence of serious respiratory depression in patients who receive narcotics for pain is similarly low. As tolerance develops to the analgesic effects of narcotics, so it does to the respiratory effects. No more than 1 per cent of patients who receive narcotics for pain develop serious respiratory depression.[3,9]

It is instructive to contrast the very low incidence of important side effects with the very high incidence of inadequate pain relief. I can't think of any other area in medicine in which such an extravagant concern for side effects so drastically limits treatment. We are used to a closer balance between risks and benefits. The relative weighting we give to risks and benefits in relieving pain should, of course, depend on the patient's medical condition and preferences. The patient with transient pain from benign disease may be unwilling to accept and should not experience more than minimal side effects. At the other extreme, concerns about addiction in the patient with terminal cancer are irrelevant, and those about respiratory depression should be secondary to relief of pain.

Given a commitment to pain relief, how is this best accomplished? The prn regimen for dispensing narcotics has been strongly criticized. Many authorities believe that it is not only punishing but inimical to the efficient use of narcotics, since the dose required to abolish pain is larger than the dose required to prevent its re-emergence.[7,10,11] The usual alternative to the prn regimen is to give the drug at fixed intervals, to prevent pain rather than to treat it. This is the regimen used at St. Christopher's Hospice in London. Both these approaches to pain relief have advantages and drawbacks, which have been well described by Beaver.[4] I would like to suggest an intermediate approach. A prn order for a range of doses could be written, but the patient asked at each specified interval whether he needs relief from pain and, if so, whether he needs a relatively small or large dose. This system would give the patient a great deal of control over his symptom relief and also allow for fluctuations in the intensity of pain. Thus, it is more flexible than the fixed schedule. More important, it has the advantage over the prn regimen that the patient is never placed in the demoralizing position of a supplicant who must hunt down his help every three or four hours. It goes without saying that the doses and frequency of administration must be fully adequate for analgesia.

Some of these issues concerning the way we physicians deal with severe pain were raised implicitly in a recent highly publicized trial in Fall River, Massachusetts (*Commonwealth vs. Ann Capute*). After five weeks of testimony, a licensed practical nurse was acquitted of the charge that she had murdered a patient with metastatic cancer by giving her large doses of morphine. She was also acquitted of a second charge, illegally dispensing morphine. Press reports of reactions to this case suggest that we are drawing the wrong lessons from it. Despite the defendant's acquittal, there are indications that hospitals, doctors, and nurses are reacting defensively. The result may be still tighter and less sensitive rationing of pain relief. A far more constructive result would be renewed attention to the problem of inadequate pain relief and to the obligation of all members of the health-care team to cooperate in treating pain. This is the doctor's job no less than the nurse's, and it is as important as diagnosis and treatment of disease.

Pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained.

MARCIA ANGELL, M.D.

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SOUNDING BOARDS

UNDRAINED BRAINS

A Modest Proposal to Recognize Some Contemporary Medical Heroes

MOST physicians are aware of the "brain drain," which siphons off trained physicians from developing countries into the manpower pool of developed countries, but unfortunately, few physicians appreciate the role of undrained brains — the bright, dedicated, highly trained physicians of the Third World who have chosen to remain and practice scientific medicine under the often daunting conditions of their native land. Unwittingly, physicians of the prosper-